THE COMMONWEALTH FUND

TRACKING TRENDS IN HEALTH SYSTEM PERFORMANCE

February 2012

The Income Divide in Health Care: How the Affordable Care Act Will Help Restore Fairness to the U.S. Health System

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Abstract: The new Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults finds nearly three of five adults in families earning less than 133 percent of the federal poverty level were uninsured for a time in 2011; two of five were uninsured for one or more years. Low- and moderate-income adults who were uninsured during the year were much less likely to have a regular source of health care than people in the same income range who were insured all year. In addition, uninsured lower-income adults were more likely than insured adults in the same income group to cite factors other than medical emergencies as reasons for going to the emergency room. These included needing a prescription drug, not having a regular doctor, or saying that other places cost too much. The Affordable Care Act will substantially narrow these inequities through an extensive set of affordable coverage options starting in 2014.

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The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Commonwealth Fund pub. 1579
Vol. 3

OVERVIEW

Recent data show a strengthening U.S. economy, but the effects of the nation's worst postwar recession linger. Some 12.8 million people remain unemployed, and a record 5.5 million have been searching for a job for longer than six months.[1] Many jobs lost during the recession have been solidly middle-class positions in large firms and state and local governments, with health care and retirement benefits. Much of the new job growth, in contrast, has been in the retail and food services industries, typically positions with low wages and no benefits. Since 2007, real median household income has declined by 6.4 percent.[2]

These employment and income trends have substantially undermined the ability of low- and moderate-income families to maintain health insurance coverage. Currently, jobs are the primary source of health insurance coverage in the United States, with employer benefits covering nearly three of five Americans.

There are few affordable options for people who do not have health insurance through a job, particularly for those with low and moderate incomes. Few are eligible for Medicaid, and seeking a plan on the individual market means paying high premiums.

The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011, finds that nearly three of five (57%) adults ages 19 to 64 in families earning less than 133 percent of the federal poverty level ($29,726 for a family of four) were uninsured for a time in 2011 and two of five (41%) were uninsured for one or more years. Among adults in households with moderate incomes—those earning between 133 percent and 249 percent of poverty ($55,875 for a family of four)—more than one-third (36%) lacked health insurance during 2011 and nearly one-quarter (23%) had been uninsured for one or more years. In contrast, only 12 percent of adults earning 400 percent of poverty or more ($89,400 for a family of four) were uninsured during the year, with 4 percent uninsured for one year or more.

Lacking health insurance significantly interferes with people's ability to get needed health care. Adults with low and moderate incomes who had been uninsured during the year were much less likely to have a regular source of health care than those who were insured all year. In addition, uninsured adults with low and moderate incomes were more likely than insured adults in the same income groups to cite factors other than medical emergencies as reasons for going to the emergency room. These included needing a prescription drug, not having a regular doctor, or saying that other places cost too much.

The survey also shows how important Medicaid and the Children's Health Insurance Program are in providing health insurance to the children in low- and moderate-income families. More than three of five (63%) adults with children under 133 percent of the poverty level and nearly two of five (38%) with incomes between 133 percent and 249 percent of poverty said that some or all of their children were covered by either program. The Affordable Care Act will extend the ability of Medicaid and CHIP to cover children and families by targeting adults in low- and moderate-income families who are most at risk of lacking health benefits through a job.

In 2014, the law will provide near-universal health insurance through a substantial expansion of Medicaid, premium tax credits that will cap premium contributions as a share of income for people purchasing private health plans through new state insurance exchanges, and new insurance market rules that will prevent health insurers from denying coverage or charging higher premiums to people with preexisting health conditions.

The law positions the United States to narrow, if not eventually eliminate, the profound income-related inequities that currently characterize the U.S. health care system. This will not only help those families in the bottom half of the income distribution who are currently struggling to gain access to health care, but also enhance the overall functioning of the health system and the economy as all Americans will have equal access to the care they need to maintain their health over time.

With this issue brief, The Commonwealth Fund launches a new series of three nationally representative online tracking surveys, conducted by the survey research firm Knowledge Networks. The longitudinal surveys will follow randomly selected panels of adults over the next several years to examine changes in their health insurance coverage and health care as the Affordable Care Act is implemented.

SURVEY FINDINGS

For Adults with Low and Moderate Incomes, Long Periods Without Health Insurance

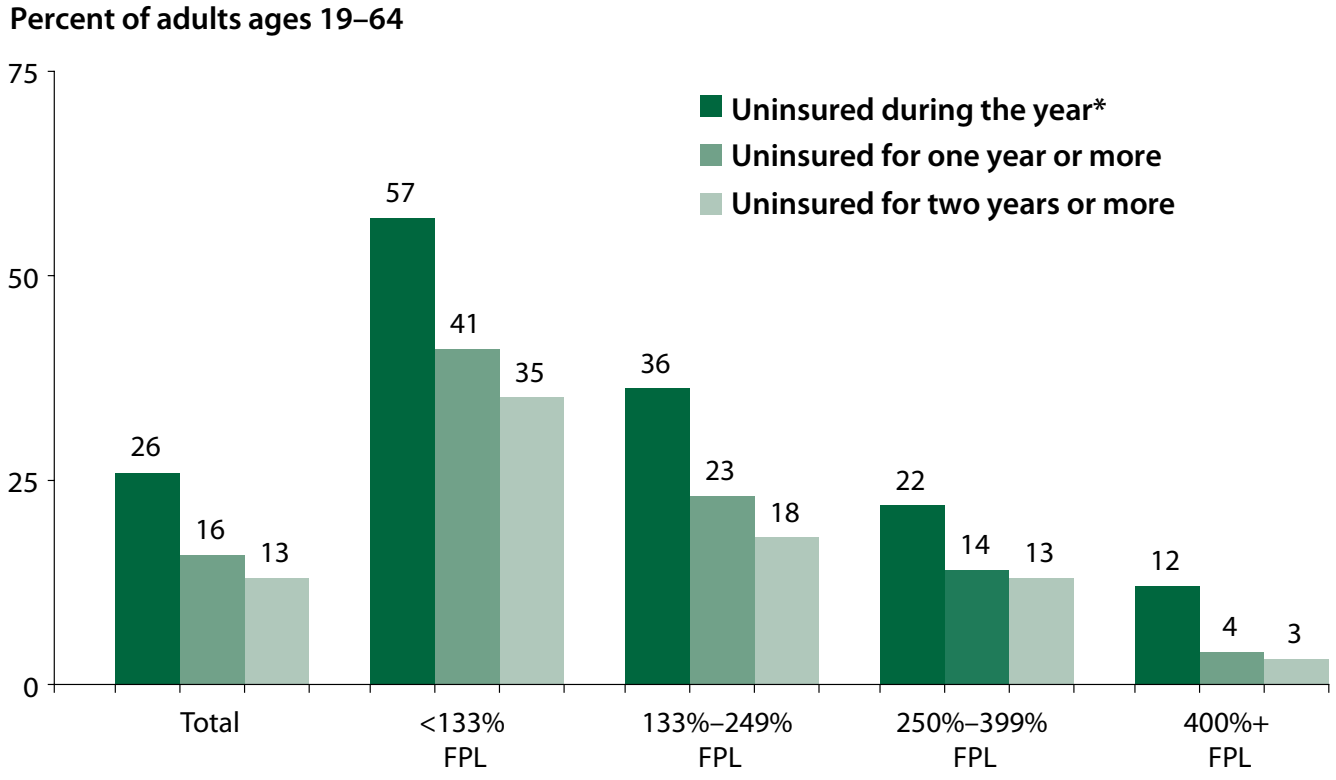
Employer-based health insurance is the primary source of insurance coverage for the under-65 population in the United States. According to U.S. Census data, 57 percent of the U.S. population under age 65, or 153 million people, had coverage through their own employer or a family member's employer in 2010.[3] People in households with low and moderate incomes are far less likely, however, to have health insurance

through an employer than those with higher incomes. Nineteen percent of people under age 65 with incomes under 133 percent of the federal poverty level and 48 percent of those with incomes of 133 percent to 249 percent of poverty had job-based health benefits in 2010, compared with 84 percent of those with incomes of 400 percent of poverty or more.[4] There are few affordable options for health insurance for adults who lack coverage through a job. Medicaid is generally only available to parents with very low incomes and few states cover adults who do not have children. People who purchase coverage on the individual insurance market must pay the full premium; in most states, they can pay higher premiums or be denied coverage on the basis of their health. In 2010, fewer than half of adults who said they had shopped for coverage on the individual market during the prior three years ended up buying a health plan.[5]

The survey asked respondents if they were uninsured at the time of the survey or, if insured, whether they had spent any time without health insurance in the past year. Adults with low and moderate incomes were at greatest risk of being uninsured. Nearly three of five (57%) adults with incomes below 133 percent of poverty were uninsured for some time during the past year (Exhibit 1). Among adults with slightly higher incomes (between 133% and 249% of poverty), 36 percent were uninsured for a time during the year. However, rates were still high even among adults with higher incomes (just under 400 percent of poverty, or $89,400 for a family of four), with 22 percent uninsured during the year.

The survey asked adults how long they had gone without health insurance. Substantial shares of adults with low and moderate incomes reported being uninsured for long periods of time. More than two of five (41%) adults with incomes below 133 percent of poverty said they had been without health insurance for a year or more and more than one-third (35%) had been uninsured for two years or more. Among adults with slightly higher incomes (between 133% and 249% of poverty), nearly one-quarter (23%) had been

Exhibit 1. Low-Income Adults Have Higher Rates of Being Uninsured for Long Periods of Time



* Combines "Insured now, time uninsured in past year" and "Uninsured now."
Note: FPL refers to federal poverty level.
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

uninsured for a year or more, and 18 percent for two or more years. Lengthy spells without coverage were also reported by adults with incomes just under 400 percent of poverty: 14 percent had been uninsured for one year or more and 13 percent for two or more years.

Poor Access to Care for Uninsured Adults with Low and Moderate Incomes

The United States spends more per capita on health care than any other industrialized country.[6] A substantial body of research comparing spending across countries has found that the primary factor in higher U.S. health care costs relative to other countries are the prices paid for physician, hospital, pharmaceutical, medical devices, and other health care services.[7] Prices for the same services vary substantially across the country and can even vary by payer within the same local markets.[8] People who have health insurance benefit from lower prices negotiated by their insurance carriers, as well as from the insurance that covers all or part of the cost of a service. Families who lack health insurance have neither the advantage of negotiated prices nor the protection of insurance.

While many people without health insurance utilize subsidized services at community health centers and safety-net hospitals, there is no nationally organized system of care for people who lack the means to pay for it. People who do not have health insurance on average receive 55 percent of the medical services of those who do have health insurance.[9] The Institute of Medicine (IOM) found that people without health insurance face such significant barriers to getting adequate care that they have fundamentally different overall life experiences than do people who are insured for most of their lives.[10]

The IOM estimated that the aggregate annualized cost of lost capital and earnings from poor health and shorter lifespans as a result of leaving millions of Americans uninsured falls between $65 billion and $130 billion a year.

The survey asked about respondents' use of health care services including whether they had a usual source of care, availability of after-hours care and emergency room use, recommended preventive care screens, challenges in finding new primary care doctors, and wait times for appointments. Adults with low and moderate incomes who lacked health insurance generally had worse care experiences than those in the same income group who had health insurance.

Usual source of care. People who have a regular doctor are more likely to receive preventive care and are more likely to adhere to physicians' treatment regimens, allowing health problems to be identified early and treated before costly hospital admissions become necessary.[11] The survey asked adults whether they had a regular doctor, doctor's group, health center, or clinic where they usually went when they needed medical care. Among adults with incomes under 250 percent of poverty, only half (52%) of those who lacked health insurance reported that they had a regular source of care, compared to virtually all (92%) adults in that income range who were insured all year (Appendix Table 2).

Differences were similar between higher-income insured and uninsured adults in having a regular source of care. Across the income spectrum, having health insurance means the difference between having a regular source of health care and not having one. However, given the much lower rates of insurance coverage among low-income adults, as a group they were far less likely than adults with higher incomes to have a regular doctor or place of care. Sixty-eight percent of respondents with incomes under 133 percent of poverty had a regular source of care compared with 86 percent of those with incomes of 400 percent of poverty or higher (Appendix Table 2).

There were differences by insurance coverage in the type of providers people identified as their usual source of care. People with low and moderate incomes who were uninsured were far less likely to cite a doctor's office as their usual source of care than were people who were uninsured in the same income range (Appendix Table 2). Thirty-one percent of adults with incomes under 250 percent of poverty who were uninsured said their usual source of care was a doctor's office or private clinic, compared with 71 percent of those who were insured in the same income range. Community health centers play an important role as a

source of care for people who are uninsured across the income spectrum: 19 percent of uninsured adults with incomes under 250 percent of poverty and 11 percent of uninsured adults with incomes of 250 percent of poverty or more identified a community health center or public clinic as their usual source of care.

After-hours and emergency room care. Very few doctors' offices in the United States have arrangements in place to allow patients to access care after regular working hours without going to the emergency room.[12] The survey asked respondents how easy or difficult it was to get medical care in the evenings, on weekends, or on holidays without going to the hospital or emergency room. More than one-quarter (27%) of respondents said they found it very difficult or somewhat difficult to get medical care after hours (Appendix Table 2). People with low incomes who had been uninsured during the year reported problems at higher rates (38%) than did low-income adults with health insurance (27%) and uninsured adults with higher incomes (25%).

People who needed after-hours care were most likely to go to an emergency room or urgent care center. More than one-quarter (28%) of respondents went to an emergency room for after-hours care in the past year and 22 percent went to an urgent care center (Appendix Table 2). Far fewer went to a primary care practice for care after hours (16%), a retail clinic (12%), or used a telephone help line (12%).

People with low incomes—including those with and without insurance—reported going to the emergency room at higher rates than did adults with higher incomes. More than two of five (44%) adults with incomes under 133 percent of poverty reported going to an emergency room during the evening or on weekends, compared with 23 percent of people with incomes of 400 percent of poverty or more.

The survey asked adults who had used the emergency room in the past year about the reasons for their visit. The majority (91%) of adults identified a medical emergency as a factor in their decision, 54 percent said that other facilities were not open, and 45 percent said they expected easy access to diagnostic testing and other tests (Appendix Table 2). One-third (34%) said they had been directed to the emergency room by a doctor, 32 percent needed a prescription drug, 21 percent said they did not have a regular doctor, and 21 percent said other places cost too much.

Adults with low and moderate incomes who were uninsured during the year were more likely than insured adults in the same income group to cite factors other than medical emergencies as reasons for going to the emergency room. These included needing a prescription drug, not having a regular doctor, or saying that other places cost too much. Among adults with incomes under 250 percent of poverty who had been to the emergency room in the past year, half of those who were uninsured said needing a prescription drug was a factor in going to the emergency room, compared with one-third (35%) of those who were insured all year (Exhibit 2, Appendix Table 2). Similarly, two of five (41%) adults in that income range who were uninsured during the year said that not having a regular doctor was a factor in their decision—more than twice the share of insured adults with similar incomes who cited that reason (16%). Finally, two of five (40%) adults with low and moderate incomes who were uninsured said the high cost of other places was a factor in their decision, compared with one of five (20%) adults in that income range with insurance who cited this reason.

The survey findings suggest that more low- and moderate-income adults with health insurance resort to emergency rooms for nonurgent care than do higher-income insured adults. For example, 35 percent of insured adults with incomes under 250 percent of poverty said they had gone to an emergency room because they needed a prescription drug, compared with 17 percent of insured adults with incomes of 250 percent of poverty or more (Appendix Table 2). Similarly, 20 percent of insured adults with low and moderate incomes cited cost as a factor in their decision to go to the emergency room, compared with only 6 percent of insured adults with higher incomes.

Preventive care. The U.S. Preventive Services Task Force gives A or B ratings to an extensive set of preventive care screenings that are likely to improve health and prevent disease. Under the Affordable Care Act, all non-grandfathered health plans (i.e., those not in existence when the law passed in March 2010) must

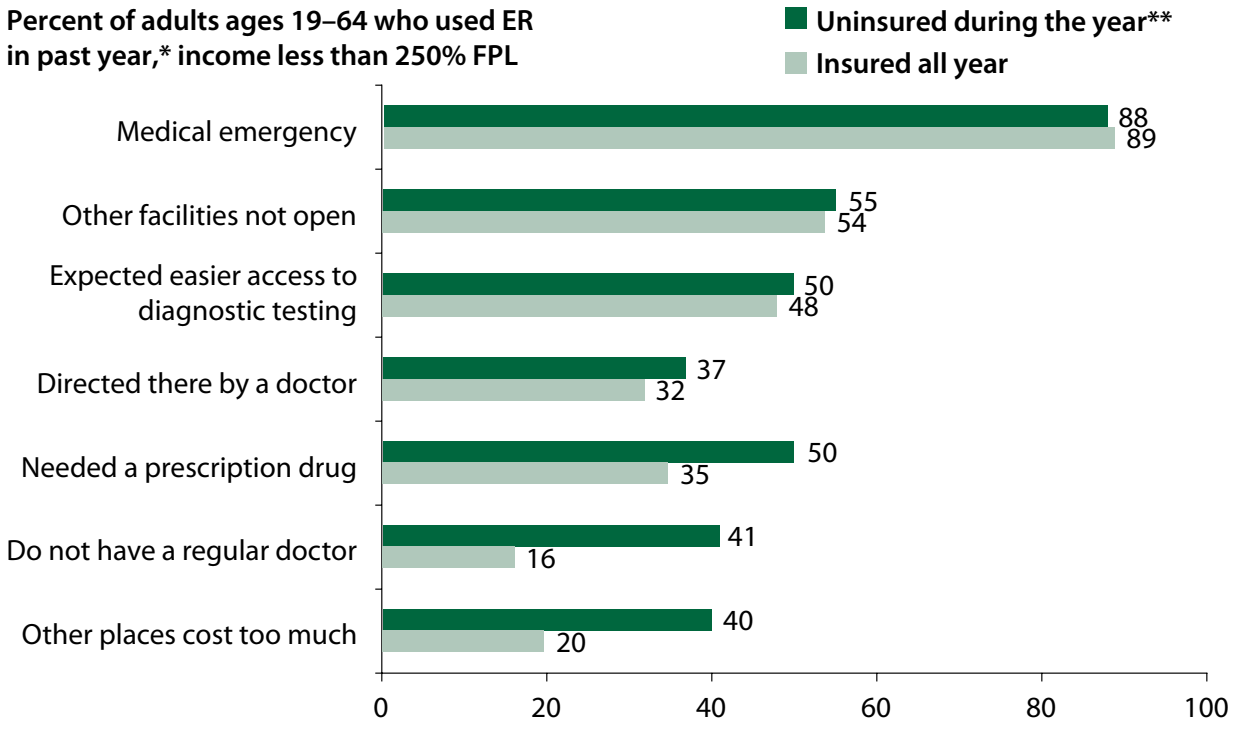
now cover the preventive care services that receive an A or B rating without cost-sharing. The survey selected five preventive care screenings and asked adults whether they had received the tests in the recommended time frame. These included:

- blood pressure checked in the past year;
- cholesterol checked in the past five years (in the past year if the respondent had hypertension or heart disease);
- for women, a Pap test in the past year, ages 19 to 29, and past three years, ages 30 to 64;
- for women, a mammogram in the past two years, ages 40 to 64;
- colon cancer screening in past five years, ages 50 to 64.

Overall, three quarters of adults were up to date with blood pressure checks but just 61 percent had had their cholesterol checked in the past five years and fewer than half (49%) of those age 50 and over had had a colon cancer screening in the past five years. Among women, two-thirds had received a Pap test or mammogram in the recommended time frame for their age (Appendix Table 2).

Rates of getting preventive tests were strikingly lower among adults without insurance. Among adults with incomes under 250 percent of poverty, only 10 percent of uninsured older adults had received a colon cancer screening in the recommended time frame, compared with half of those with health insurance (Exhibit 3, Appendix Table 2). Just one-third (32%) of uninsured women ages 40–64 with low and moderate incomes had had a mammogram, half the rate (66%) of women who were insured all year in that income range. Finally, only one-third (35%) of uninsured adults with low and moderate incomes had had their cholesterol checked in the past five years, about half the rate (64%) of adults in that income range who were insured all year.

Exhibit 2. Factors in Decision to Visit an Emergency Room, Adults with Low and Moderate Incomes



* Respondent used ER at least once in past 12 months to get care for themselves or family member in evenings or on weekends.
** Combines "Insured now, time uninsured in past year" and "Uninsured now."
Note: FPL refers to federal poverty level.
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

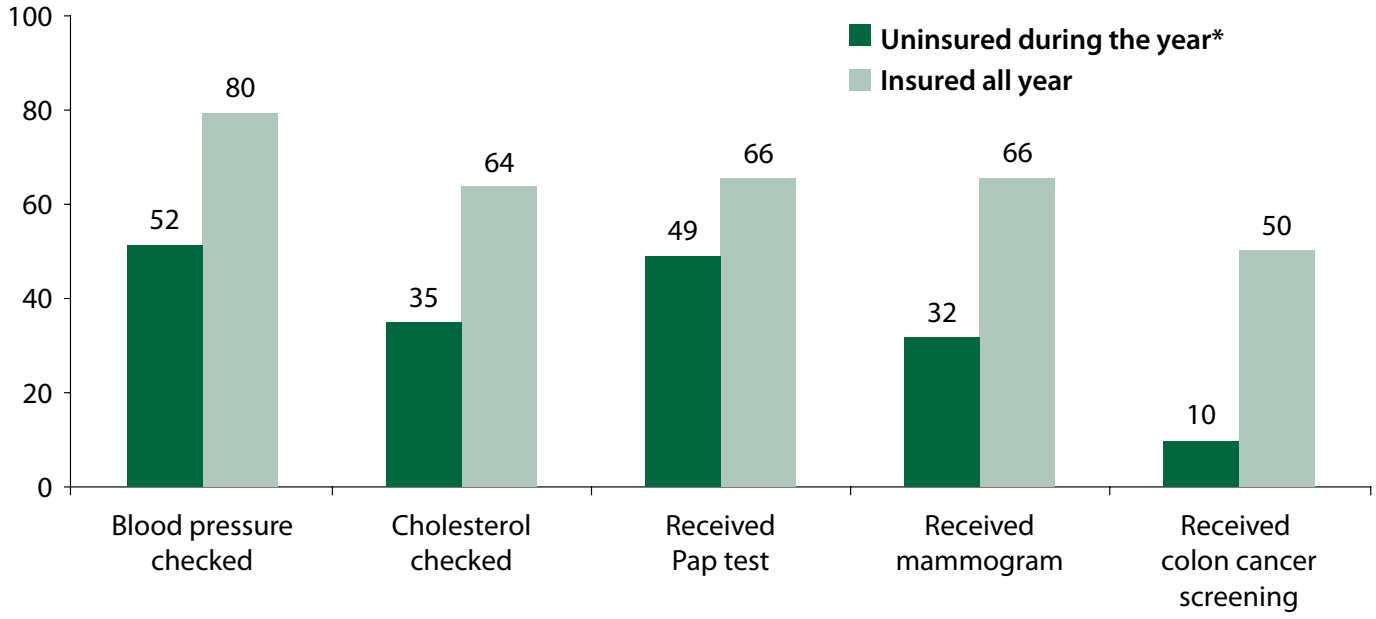
While having health insurance made the biggest difference in whether or not people received timely preventive care screens among both lower- and higher-income adults, adults with lower incomes who had health insurance had somewhat lower rates of receiving preventive care tests than insured adults with higher incomes. Adults with incomes under 250 percent of poverty ($55,875 for a family of four) who were insured all year reported slightly lower rates of blood pressure and cholesterol tests, mammograms, Pap tests, and colon cancer screenings than did insured adults with incomes of 250 percent of poverty or higher (Appendix Table 2).

The survey asked respondents about reasons they were not up to date with the three cancer screenings (Pap test, mammogram, colon cancer screening). Overall, the most commonly cited reasons were the respondent did not think he or she needed the test, did not get around to making an appointment, or the test was too expensive (Exhibit 4). But there were substantial differences in reasons given for not getting a cancer screening between uninsured and insured adults. For example, people who had been uninsured for a time during the year were much more likely to say they had not received a test because it was too expensive than were those who were insured all year. Two of five (40%) women who were uninsured said that they had not had a Pap test in the recommended time frame because it cost too much, four times the rate of women who were insured all year. Similarly one-third (33%) of uninsured older adults who had not had a colon cancer screening in the past five years said that it cost too much, compared with 5 percent of insured older adults. In contrast, people who had insurance were much more likely than uninsured adults to say that they had not had a test because they "did not get around" to making an appointment.

A sizeable share of adults cited reasons other than those offered in the survey for not getting one of the cancer screenings. Of those, the most often-named reasons included: a doctor did not refer them or recommended a different time period for the test; being afraid or not wanting to have the test; surgery that made the test unnecessary; lack of health insurance or money; believing the test was not necessary.

Exhibit 3. Uninsured Adults with Low and Moderate Incomes Are Less Likely to Be Up to Date with Recommended Preventive Tests

Percent of adults ages 19–64, income less than 250% FPL



Notes: FPL refers to federal poverty level. Preventive tests: blood pressure checked in past year; cholesterol checked in past five years (in past year if has hypertension or heart disease); Pap test in past year for females ages 19–29, in past three years for ages 30–64; mammogram in past two years for females ages 40–64; and colon cancer screening in past five years for adults ages 50–64.
* Combines "Insured now, time uninsured in past year" and "Uninsured now."
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

Exhibit 4. Reasons for Skipping Cancer Screening Tests

Percent of adults ages 19–64 who skipped recommended preventive care

	Pap test*			Colon cancer screening**			Mammogram***^	
	Total	Insured all year	Uninsured during the year	Total	Insured all year	Uninsured during the year	Total	Insured all year
Reasons for skipping cancer screenings:								
Did not think I needed it	30%	33%	26%	38%	38%	37%	26%	27%
Did not get around to making an appointment	23	28	13	22	27	8	29	40
Too expensive	21	10	40	13	5	33	25	9
No doctor or appointment available	4	3	6	3	2	5	1	0
Could not take time off work	2	3	1	2	1	3	3	4
Other	20	24	13	21	25	12	16	20

* Did not have Pap test in past year for females ages 19–29, in past three years for ages 30–64.
** Did not have colon cancer screening in past five years for adults ages 50–64.
*** Did not have mammogram in past two years for females ages 40–64.
^ Sample size too small to report mammogram results for "uninsured during the year."
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

Finding a new primary care doctor. Moving to a new city, changing jobs or insurance plans, or graduating from high school or college can necessitate finding new physicians. The survey asked people about the ease with which they were able to find a new primary care doctor. About a quarter (23%) of adults said that they or a spouse or partner had tried to find a new primary care doctor in the past three years (Appendix Table 3). Of those, about one-third (35%) said that finding a new doctor had been somewhat or very difficult. People who lacked health insurance had the greatest difficulties finding a doctor: half (51%) of adults who had been uninsured during the year said that it had been somewhat or very difficult to find a new primary care doctor, compared with 30 percent of adults who had been insured all year.

While there were not large differences by income in people's ability to find a primary care doctor, the problems people encountered were very different depending on income. Among those adults who had looked for a primary care doctor in the past three years, half of those with incomes under 133 percent of poverty said that a doctor's office or clinic would not accept their insurance (Appendix Table 3). In contrast, only 25 percent of adults with incomes of 400 percent of poverty or more encountered a similar problem. Adults with low incomes were also much more likely than those with higher incomes to say that they could not find a doctor they could afford: 41 percent of adults with incomes under 133 percent of poverty could not find an affordable doctor, compared with 14 percent of those with incomes of 400 percent of poverty of more. People who were uninsured were also far more likely to cite affordability as a problem than were those who were insured all year.

Wait times for appointments. Long wait times for appointments can interfere with people's ability to maintain their health, particularly for those with chronic health problems. The survey asked adults who had a new primary care physician how long they had to wait to get their first appointment. More than half (57%) of adults in the survey said they had secured an appointment within 14 days of finding a new physician (Appendix Table 3). There were few differences in wait times for first appointments by income or insurance status.

However, people with low incomes or those uninsured reported much longer wait times for

appointments with specialists than did adults with higher incomes. Overall, among adults who had seen a specialist in the past year, more than half (52%) waited less than two weeks for an appointment (Appendix Table 3). People who were uninsured for any time and those with low incomes were more likely to experience long wait times. More than one-quarter of adults who were uninsured during the year (26%) or who had incomes under 133 percent of poverty (28%) waited four weeks or more for an appointment with a specialist, compared with 17 percent of those who were insured all year and 16 percent of those with incomes of 400 percent of poverty or more.

Medicaid and the Children's Health Insurance Program: Critical Coverage for Families with Low and Moderate Incomes

Medicaid and the Children's Health Insurance Program (CHIP) are critical sources of coverage for families with low and moderate incomes. Currently, states must provide Medicaid to children under age 6 in families with incomes under 133 percent of poverty, pregnant women in families with incomes under 133 percent, and children up to age 19 with household income under the poverty level. But most states have substantially expanded insurance coverage for children beyond those income levels through Medicaid and CHIP.[13] This has resulted in a dramatic decline in the number of uninsured children nationwide since the late 1990s, even as more adults have lost coverage over that time period.[14] While several states have also expanded eligibility for parents of dependent children, income eligibility thresholds for parents in most states are well below the federal poverty level. In addition, in most states, adults who do not have children are not currently eligible for Medicaid, regardless of income.

The survey asked adults whether they were currently enrolled in Medicaid or if they had children who were enrolled in either Medicaid or CHIP. Nearly two-thirds (63%) of adults with incomes below 133 percent of poverty and nearly one-third (32%) with incomes between 133 percent and 249 percent of poverty reported that they or their children were enrolled in Medicaid or CHIP at the time of the survey or that they had been enrolled in Medicaid in the past two years (Exhibit 5). This group mainly consisted of parents and children in a household or only the children in the household.

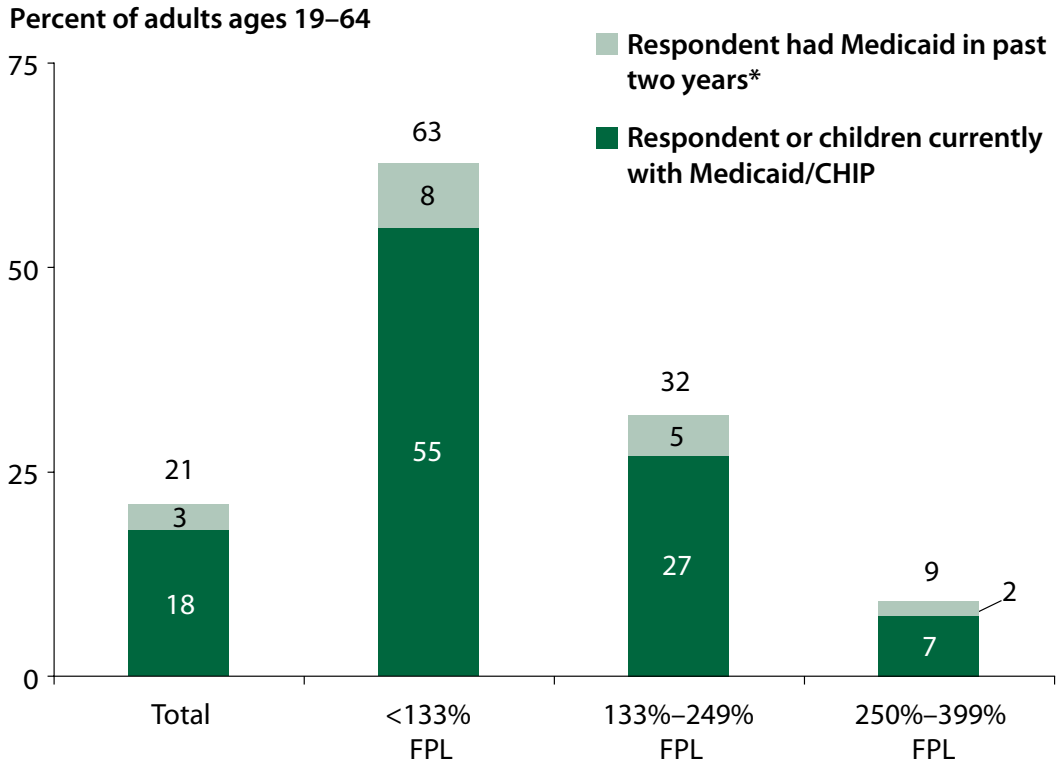
Medicaid and CHIP are particularly important sources of health insurance for children in low- and moderate-income families. Nearly two-thirds (63%) of adults with children under 133 percent of the poverty level and more than one-third (38%) of those with incomes between 133 percent and 249 percent of poverty said some or all of their children were enrolled in Medicaid or CHIP (Exhibit 6). Still, more than three of 10 (31%) adults with children with incomes under 133 percent of poverty and 20 percent of those earning between 133 percent and 399 percent of poverty reported some or all of their children were uninsured in 2011, compared with 12 percent of adults earning 400 percent of poverty or more who had uninsured children.

THE AFFORDABLE CARE ACT: CAN IT NARROW THE INCOME DIVIDE IN HEALTH CARE COVERAGE AND ACCESS?

The striking differences in the health system experiences between low- and moderate-income families and those with higher incomes will be significantly narrowed by provisions in the Affordable Care Act. A large number of coverage provisions went into effect last year and many are already having an effect on people's health insurance. These provisions include allowing young adults under age 26 to stay on or join their parents' policies, eliminating preexisting condition exclusions for children under age 19, banning lifetime benefit limits, covering preventive services with no cost-sharing, and establishing preexisting condition insurance plans that are enrolling people with chronic health problems in all 50 states.[15] The law has effectively reversed a decade-long increase in the number of young adults without health insurance since it went into effect in September 2010.[16] A recent report by the U.S. Department of Health and Human Services found that 2.5 million 19-to-25 year olds gained health insurance coverage between September 2010 and June 2011.[17]

The law's most far-reaching changes will begin in 2014. A new array of comprehensive and

Exhibit 5. Medicaid Is an Important Source of Coverage for Families and Children with Low and Moderate Incomes



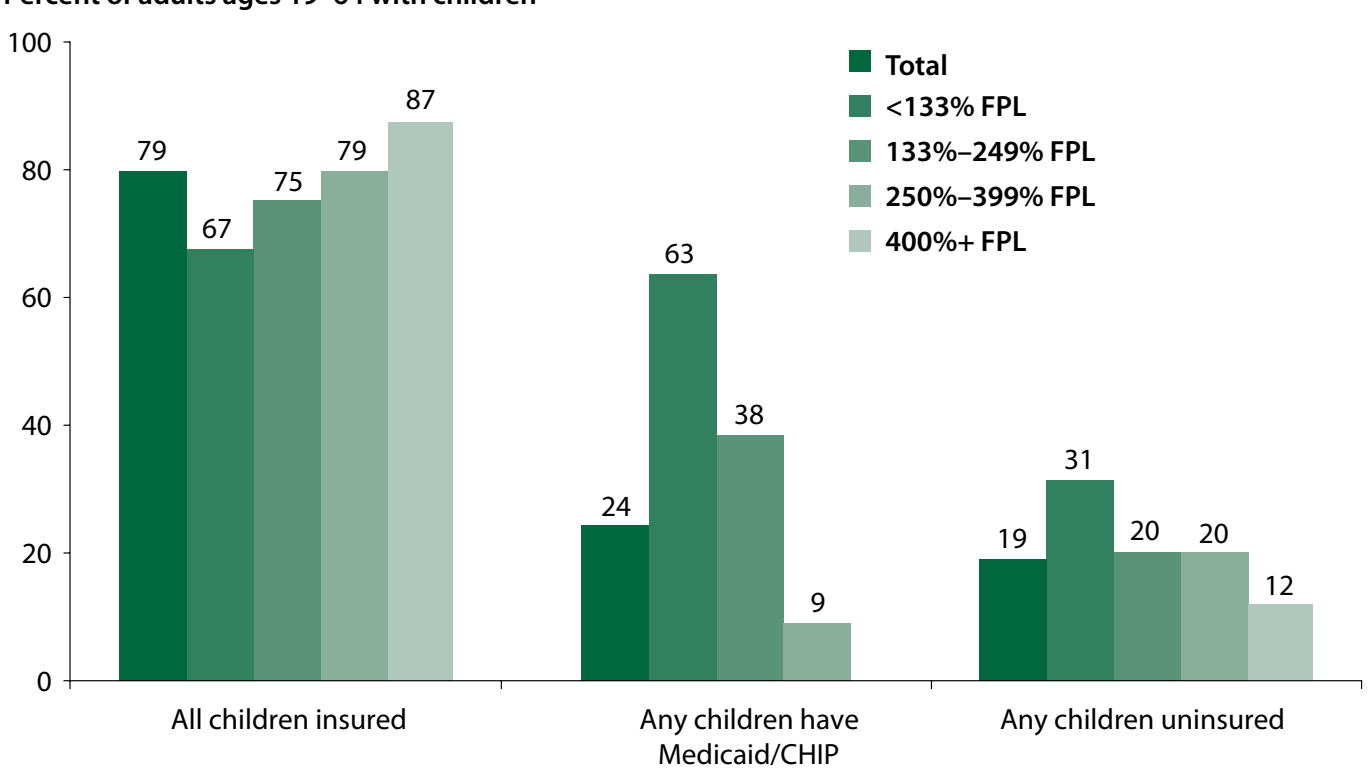
Notes: FPL refers to federal poverty level. Numbers may not sum to total because of rounding.
* Had Medicaid in past two years, but does not currently receive Medicaid and does not have children who receive Medicaid/CHIP.
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

affordable health insurance options will become available to families across income brackets with new subsidies for those with low and moderate incomes. Health insurers will be banned from underwriting or denying coverage on the basis of health, and health insurance policies will be required to meet new federal standards in benefits covered and cost-sharing. The law will bring sweeping change to the insurance system, ensuring near-universal coverage in a country with nearly 50 million people uninsured, most in families with low and moderate incomes.

Expanded income eligibility for Medicaid. The law substantially expands eligibility for Medicaid for all legal residents with incomes up to 133 percent of the federal poverty level—about $14,484 for a single adult or $29,726 for a family of four. This represents a substantial change in Medicaid's coverage of adults—currently few people, with the exception of very-low-income parents and pregnant women, have been eligible for coverage through the program. Children will be eligible at higher income categories in Medicaid and CHIP depending on standards set by the states in which they live. The federal government will provide the bulk of financing for the Medicaid expansion, covering 100 percent of the costs in most states through 2016 before gradually reducing its contribution to 90 percent for all states by 2020. The Congressional Budget Office estimates that 16 million people will become newly covered under Medicaid by 2020.[18]

State insurance exchanges. The state insurance exchanges are the centerpiece of the Affordable Care Act's coverage expansions, providing insurance options for individuals and small businesses. The exchanges will create a new marketplace that will serve as the central portal through which people will go for coverage if they do not have an affordable employer-based health plan. The individual and small-group markets

Exhibit 6. Medicaid Is Particularly Important for Low- and Moderate-Income Families with Children



* Children under age 26.
Note: FPL refers to federal poverty level.
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

will continue to function outside of the exchanges, but new insurance market regulations against underwriting on the basis of health and other market reforms will apply to plans sold inside and outside the exchanges. People will be able to access the exchanges, either in person or online, fill out one application, and receive a determination of eligibility, depending on income, for various program under the law, including Medicaid, the Children's Health Insurance Program, the Basic Health Program that states may choose to operate for people earning between 133 and 200 percent of poverty, or premium tax credits for private "qualified health plans" sold in the exchanges.[19] About 17 million people are estimated to become newly insured through the new qualified health plans in the exchanges, most with subsidies, by 2020.[20]

Premium tax credits and cost-sharing protections. Starting in 2014, people with household incomes from 100 percent to 400 percent of the poverty level ($22,350 to $89,400 for a family of four) who lack access to affordable insurance will be eligible for a tax credit to offset the cost of premiums for private health plans purchased through the state insurance exchanges.[21] People with an offer of employer coverage will be eligible for the tax credits if they would have to spend more than 9.5 percent of household income on premium contributions or if their plan provides less than a minimum level of cost protection—at least 60 percent of an individual's total medical costs on average for the year.

In general, people with incomes under 133 percent of poverty will be eligible for Medicaid (Exhibit 7), but legal immigrants in the five-year waiting period for Medicaid are eligible for tax credits. Under the law, taxpayers eligible for tax credits are required to make contributions to their premiums, from 2 percent to 9.5 percent of their income. Those eligible for tax credits will have a choice of private qualified health plans sold through the exchanges that will offer a comprehensive set of benefits known as the essential benefit package.[22]

Insurers will offer these plans at four tiers of cost-sharing: bronze plans (covering on average 60% of annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs). However, the average costs covered by the silver plan will be increased to 94 percent for those with incomes up to 149 percent of poverty, to 87 percent for those with incomes between 150 percent and 199 percent of poverty, and 73 percent for those with incomes between 200 percent and 249 percent of poverty. In addition, qualified health plans will have limits on out-of-pocket spending related to income that range from $1,983 for an individual policy and $3,967 for a family policy for those earning up to 199 percent of poverty ($44,700 for a family of four) to $3,967 for a single policy and $7,933 for a family policy for those earning up to 399 percent of poverty (just under $89,400 for a family of four). For those earning 400 percent of poverty or more, out-of-pocket limits are set at the level of health saving accounts, or $5,950 for a single policy and $11,900 for a family policy.

Individual requirement to have health insurance. A critical part of the Affordable Care Act is the requirement that everyone have health insurance coverage. This will ensure that the new insurance exchanges will include healthy people and those in poorer health, distributing risk across large and diverse risk pools and preventing rapid increases in premiums over time. Doing so will help the insurance exchanges resemble the risk pools of today's large employers, where young and healthy workers support the higher costs of older or less-healthy workers. Adverse selection, or the tendency for people to buy coverage when they are sick rather than when they are healthy, is the primary reason the individual and small-group insurance markets have been characterized by extensive underwriting, high premiums, high administrative costs, and overall dysfunction. The individual mandate to have health insurance coupled with reforms such as bans against underwriting and the new insurance exchanges with subsidized coverage will create market structures with the capacity to deliver affordable health insurance to people who lack employer-based coverage.

Beginning in 2014, all U.S. citizens and legal residents will be required to maintain minimum

Exhibit 7. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

Federal poverty level	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: silver plan
<133%	S: <$14,484 F: <$29,726	2% (or Medicaid)	S: $1,983 F: $3,967	94%
133%–149%	S: $14,484 – <$16,335 F: $29,726 – <$33,525	3.0%–4.0%		94%
150%–199%	S: $16,335 – <$21,780 F: $33,525 – <$44,700	4.0%–6.3%		87%
200%–249%	S: $21,780 – <$27,225 F: $44,700 – <$55,875	6.3%–8.05%	S: $2,975 F: $5,950	73%
250%–299%	S: $27,225 – <$32,670 F: $55,875 – <$67,050	8.05%–9.5%		70%
300%–399%	S: $32,670 – <$43,560 F: $67,050 – <$89,400	9.5%	S: $3,967 F: $7,933	70%
400%+	S: $43,560+ F: $89,400+	—	S: $5,950 F: $11,900	—

Four levels of cost-sharing: 1st tier (Bronze) actuarial value: 60%
2nd tier (Silver) actuarial value: 70%
3rd tier (Gold) actuarial value: 80%
4th tier (Platinum) actuarial value: 90%

Catastrophic policy with essential benefits package available to young adults and people whose premiums are 8%+ of income

Notes: Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for the silver plan.
Source: Federal poverty levels are for 2011; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

essential health insurance coverage through the individual insurance market, insurance exchanges, public programs, or employers—or face a penalty. There are some exemptions: individuals who cannot find a health plan that costs less than 8 percent of their income, net of subsidies and employer contributions; people who have incomes below the tax-filing threshold ($9,350 for an individual and $18,700 for a family); people who have been without insurance for less than three months; and certain other circumstances. People who are not exempt from the mandate and cannot demonstrate on a tax form that they have health insurance will be required to pay a penalty equal to the greater of $95 or 1 percent of applicable income (i.e., income in excess of the tax-filing threshold) in 2014, $325 or 2 percent of applicable income in 2015, and $695 or 2.5 percent of applicable income in 2016, up to a maximum of $2,085 per family.[23] The tax, which will be assessed through the tax code and applied as an additional amount of federal tax owed, will be prorated for partial years of noncompliance.

Will the combination of the Medicaid expansion and the premium tax credits make health insurance coverage affordable for families with low and moderate incomes, or will mandated coverage present a new financial burden? An analysis of the law's coverage provisions by Jonathan Gruber found that nearly all Americans would be able to afford the costs of health insurance and health care when the law is fully implemented.[24] Gruber, however, did find that there are risks: people who experience high health care costs in a given year as a result of a serious illness might not have room in their budgets for the higher out-pocket costs. Those earning between 200 percent and 250 percent of poverty would be the most at risk of unaffordable health expenses.

BEYOND THE AFFORDABLE CARE ACT: FURTHER STEPS TO IMPROVE EQUITY IN HEALTH CARE

The survey reveals yawning divides in access to health care between people with and without insurance coverage in low- and moderate-income households. Nearly all adults in the survey with health insurance, regardless of income level, had a regular source of care while only half of those without insurance did. Not having a regular doctor was a major reason why many uninsured adults with low and moderate incomes went to emergency rooms. Similarly, people with health insurance in low- and moderate-income households were substantially more likely to have had preventive care tests in the recommended time frame than were adults in that income group who did not have health insurance. These findings strongly suggest that universal coverage—which will be a reality in 2014 under the Affordable Care Act—will help equalize access to physicians and preventive care across the income spectrum, though it will be critical that insurance coverage for low- and moderate-income families remains affordable and comprehensive over time.

The survey findings, however, also point to areas where income-related differences in access to care might persist, even after 2014. For example, people with low incomes were more likely to go to emergency rooms for after-hours care than those with higher incomes, regardless of their insurance status. In addition, adults with low and moderate incomes who had health insurance were much more likely to cite non-emergency reasons for going to emergency rooms, like needing a prescription drug or the high cost of other options, than were insured adults with higher incomes. People with low incomes were much more likely to encounter physicians who would not accept their health insurance than were higher-income adults. And adults with low incomes who needed specialists faced much longer wait times for appointments on average than adults with higher incomes.

Collectively, these findings suggest that universal health insurance coverage under the Affordable Care Act is a necessary, though not sufficient, condition for ensuring equal access to timely health care across income levels. People will need both health insurance and timely access to physicians and clinics who know them and their medical histories. Several provisions in the law address some of the access barriers identified in the survey. For example, the law places an emphasis

on strengthening primary care through a number of initiatives.[25] Payment rates to primary care physicians are increased in the Medicaid program to Medicare levels, though only for two years. This provision will help people with low incomes find physicians willing to accept their insurance, albeit temporarily. The law also provides states the option of paying higher reimbursement rates to providers who provide "health homes" to Medicaid beneficiaries with chronic health problems. Such health homes are comprised of designated primary care providers who team with other health care professionals to provide comprehensive care management, care coordination and health promotion, transitional care between hospital and primary care, referral to community and social services, and patient and family engagement.

Several grant programs in the law will enable states to develop and spread new approaches to patient-centered and coordinated health care for vulnerable populations. The new Innovation Center at the Center for Medicare and Medicaid Services has launched two demonstration projects aimed at improving primary care among low income patients: Medicare is joining Medicaid and commercial payers in eight states to test patient-centered medical home models and 500 federally qualified health centers will receive additional payments to help them become patient centered medical homes. Finally the law provides $11 billion in new funding for community health centers, with $9.5 billion earmarked for health centers in high-need communities. In future years, the law will authorize a higher level of funding for these centers. If the funds are appropriated, 50 million new patients could get care at community health centers by 2019.[26]

The Commonwealth Fund Commission on a High Performance Health System laid out a framework in 2011 to help ensure greater equity for vulnerable populations in the U.S. as the provisions of the law are implemented.[27] The framework comprises three major tenets:

- Ensure that insurance coverage results in adequate access and financial protection;
- Strengthen the care delivery systems serving vulnerable populations; and
- Coordinate health care delivery system efforts with other community resources, including public health services.

The Affordable Care Act lays the foundation for achieving these goals. But realizing its full potential and vision of a more equitable health care system will require careful monitoring of the experiences of low- and moderate-income families and other vulnerable populations and the willingness of policymakers to implement new policies and reforms over time.

CONCLUSION

Greater income inequality in the United States in recent years is well-documented. According to the Congressional Budget Office, real after-tax income rose by 275 percent between 1979 and 2007 for the top 1 percent of earners, by less than 40 percent for the middle 60 percent of earners, and by approximately 18 percent for the bottom 20 percent of earners.[28] Internationally, the U.S. has the fourth-highest level of income inequality behind Chile, Mexico, and Turkey among Organization for Economic Cooperation and Development countries.[29]

As the findings of this survey illustrate, widening income inequality has manifested itself powerfully in the U.S. health care system. People in the bottom half of the income distribution, on average, have dramatically different health care experiences than those at the top. The consequences of this widening gulf are strikingly evident in the health insurance system—having health insurance coverage is nearly entirely dependent on whether it is offered through a job. People with low and moderate incomes run the highest risk of lacking job-based health insurance, are least able to afford the cost of coverage if they have to buy it on their own, and are the most at risk of not being able to afford care in the absence of health insurance coverage. Because of this, in the United States, problems getting needed health care are disproportionately concentrated among low- and moderate-income families.

With the extensive improvements in health insurance coverage provided by the Affordable Care Act, the United States is poised to narrow if not eventually eliminate the profound inequity that currently characterizes the health care system. The provisions of the law are targeted precisely on leveling the playing field so that all U.S. families can gain the health care they need regardless of income.

But to ensure that the greater equity in health care envisioned by the law is realized, it will be necessary to monitor the experience of low- and moderate-income families and other vulnerable populations as the law is implemented. This new tracking survey will help aid that effort in the years to come.

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Appendix Table 1. Demographics by Income

		Federal poverty level					
	Total (ages 19–64)	Below 133% FPL	133%–249% FPL	250%–399% FPL	400% FPL or more	Below 250% FPL	250% FPL or more
Total (millions)	186.7	30.4	35.3	39.8	81.1	65.7	120.9
Percent distribution	100%	16%	19%	21%	43%	35%	65%
Unweighted n	2134	495	482	403	754	977	1157
Age							
19–29	25	19	24	20	37	43	57
30–49	41	16	19	21	44	35	65
50–64	34	14	16	22	48	30	70
Gender							
Female	51	17	20	21	41	37	63
Male	49	15	18	21	46	33	67
Race/Ethnicity							
White	66	10	17	23	50	27	73
Black	12	29	24	19	28	53	47
Hispanic	15	31	25	18	26	56	44
Other/Mixed	7	18	16	22	44	34	66
Education							
Less than high school degree	8	56	21	12	11	77	23
High school degree or equivalent	27	24	22	26	27	46	54
Some college/technical	29	12	23	24	41	35	65
College graduate or higher	34	4	12	17	66	17	83
Health Status							
Fair/Poor health status, or any chronic condition or disability^	53	19	19	20	42	38	62
No health problem	47	13	19	23	45	32	68
Insurance Status							
Insured all year	74	10	16	22	52	26	74
Insured now, time uninsured in past year	10	36	24	17	23	60	40
Uninsured now	16	36	28	19	17	64	36
Total uninsured during the year*	26	36	26	18	19	62	38
Insurance Type^^							
Employer	73	4	15	24	57	19	81
Medicaid	8	66	21	4	9	87	13
Medicare	6	51	27	14	9	78	22
Individual	6	3	17	26	54	20	80
Other	6	20	30	17	34	50	50
Adult Work Status							
Full time	51	8	16	22	54	23	77
Part time	11	21	22	26	32	42	58
Not currently employed	36	28	22	18	32	49	51
Employer Size**							
10 employees or less	18	18	19	27	36	37	63
11–24 employees	9	22	19	18	42	41	59
25–99 employees	14	16	23	26	35	39	61
100–499 employees	16	4	19	21	57	22	78
500 or more employees	43	5	13	22	60	18	82

Note: FPL refers to federal poverty level.

^ Respondent rated their health status as fair or poor, has a disability or chronic disease that keeps them from working full time or limits housework/other daily activities, or has any of the following chronic conditions: asthma, chronic bronchitis, or chronic obstructive pulmonary disease; cancer (any type except skin cancer); chronic pain; depression; diabetes; heart attack; heart disease; high blood pressure; high cholesterol; mental health condition; osteoarthritis; or stroke.

* Combines "Insured now, time uninsured in past year" and "Uninsured now."

** Among full- and part-time employed adults ages 19–64.

^^ Base: Insured respondents.

Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

Appendix Table 2. Access to Primary Care, After-Hours Care, and Preventive Care by Income and Insurance Gaps

		Federal poverty level				Below 250% FPL		250% FPL or more	
	Total (ages 19–64)	Below 133% FPL	133%–249% FPL	250%–399% FPL	400% FPL or more	Uninsured during the year*	Insured all year	Uninsured during the year*	Insured all year
Total (millions)	186.7	30.4	35.3	39.8	81.1	30.0	35.8	18.2	102.7
Percent distribution	100%	16%	19%	21%	43%	16%	19%	10%	55%
Unweighted n	2134	495	482	403	754	437	540	151	1006
PRIMARY CARE									
Has regular doctor, doctors group, health center, or clinic	81	68	79	84	86	52	92	51	92
Usual place of care^									
Doctor's office or private clinic	69	43	62	73	80	31	71	46	83
Community health center or other public clinic	8	18	10	6	3	19	9	11	3
Emergency room	3	11	4	2	1	10	5	3	1
Other**	9	9	11	10	8	11	9	13	8
Never needed care	4	8	4	3	3	9	3	8	2
No regular place of care	5	12	7	5	3	18	2	11	2
AFTER-HOURS CARE									
Ease or difficulty in getting medical care in the evenings, on weekends, or holidays without going to the hospital or emergency room (ER)^^									
Very/Somewhat easy	40	31	37	41	44	26	40	37	44
Very/Somewhat difficult	27	35	29	23	25	38	27	25	24
Used service at least once in past year in evening or on weekend (to get care for respondent or a family member)									
Primary care practice	16	21	17	15	14	18	19	17	14
Telephone help line	12	14	17	10	10	14	17	7	11
Retail clinic	12	13	16	8	12	15	14	20	9
Urgent care center	22	21	22	18	25	20	22	18	23
Emergency room	28	44	33	21	23	36	40	28	22
Factors in decision to visit the ER^^^:									
Medical emergency	91	87	90	94	93	88	89	—	93
Other facilities not open	54	54	55	45	56	55	54	—	52
Expected easier access to diagnostic testing and other tests	45	49	48	50	39	50	48	—	39
Directed there by doctor	34	37	32	28	37	37	32	—	31
Needed a prescription drug	32	47	35	29	20	50	35	—	17
Do not have regular doctor	21	31	22	21	13	41	16	—	9
Other places cost too much	21	35	22	19	10	40	20	—	6

	Total (ages 19–64)	Federal poverty level				Below 250% FPL		250% FPL or more	
		Below 133% FPL	133%–249% FPL	250%–399% FPL	400% FPL or more	Uninsured during the year*	Insured all year	Uninsured during the year*	Insured all year
PREVENTIVE CARE									
Blood pressure checked in past year	75	64	70	75	81	52	80	51	84
Cholesterol checked in past 5 years (past year if hypertension or heart disease)	61	51	51	59	70	35	64	33	72
Received Pap test in past year (females ages 19–29), in past 3 years (females age 30–64)	66	59	57	62	75	49	66	—	74
Received mammogram in past 2 years (females ages 40–64)	66	51	56	64	74	32	66	—	77
Received colon cancer screening in past 5 years (ages 50–64)	49	36	34	52	56	10	50	—	59

Note: FPL refers to federal poverty level.
— Sample size too small to report results.
* Combines "Insured now, time uninsured in past year" and "Uninsured now."
** Includes hospital outpatient department, urgent care center, retail clinic and some other place.
^ Respondents who did not provide an answer to this question are included in the distribution but not shown in the table.
^^ Respondents who have never needed care in the evenings, weekends, or holidays are excluded from the distribution.
^^^ Base: Respondent visited ER at least once in past 12 months to get care for themselves or family member in evenings or on weekends.
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

Appendix Table 3. Finding a Primary Care Doctor and Access to Specialist Care by Income and Insurance Continuity

	Total (ages 19–64)	Federal poverty level						Insured all year	Uninsured during the year*
		Below 133% FPL	133%–249% FPL	250%–399% FPL	400% FPL or more	Below 250% FPL	250% FPL or more		
PRIMARY CARE									
Respondent or spouse/partner tried to find a new primary care doctor in past 3 years	23	19	22	23	24	20	24	24	18
Finding a new primary care doctor^									
Very easy	30	21	23	42	29	22	33	32	19
Somewhat easy	32	28	37	33	30	33	31	34	24
Somewhat difficult	24	28	26	9	28	27	22	22	31
Very difficult	11	15	11	11	10	13	10	8	20
Could not find a primary care doctor	4	7	3	4	3	5	4	4	5
Problems finding a new primary care doctor^									
Doctor's office/Clinic did not accept your insurance	30	50	28	29	25	38	26	27	38
Doctor's office/Clinic would not accept you as a new patient	28	38	24	26	27	30	27	25	41
Could not find a doctor you could afford	19	41	25	10	14	32	13	12	43
Any of the above	46	66	45	42	42	54	42	40	68
Wait for first appointment with new primary care doctor^^									
Within 7 days	35	—	37	44	30	37	35	35	37
8–14 days	21	—	24	19	21	24	20	22	19
15–30 days	23	—	26	21	21	26	21	22	23
More than 30 days–6 weeks	8	—	6	8	10	5	9	9	3
More than 6 weeks	5	—	1	4	6	2	6	4	6
Have not tried to make an appointment	8	—	7	4	12	6	9	7	12
SPECIALIST CARE									
Respondent saw or needed to see a specialist in past 12 months	38	34	32	36	43	33	40	43	23
Wait for most recent specialist appointment^^^									
Less than 2 weeks	52	45	47	54	55	46	55	53	45
2 weeks to less than 4 weeks	29	26	28	33	29	27	30	30	27
4 weeks to less than 8 weeks	12	11	18	9	12	14	11	12	9
8 weeks or more	6	17	7	4	4	12	4	5	17

Note: FPL refers to federal poverty level.
* Combines "Insured now, time uninsured in past year" and "Uninsured now."
^ Base: respondent or spouse/partner tried to find a new primary care doctor in the past 3 years.
^^ Base: respondent or spouse/partner found a new primary care doctor in the past 3 years.
^^^ Base: Respondent seen by a specialist in the past 12 months.
— Sample size too small to report results.
Source: The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011.

Methodology

With this survey, The Commonwealth Fund launches a new series of three longitudinal nationally representative online tracking surveys that will follow randomly selected panels of adults over the next several years to examine changes in their health insurance coverage and health care as the Affordable Care Act is implemented. The online research firm Knowledge Networks is conducting the three tracking surveys of:

1. adults ages 19–64, with an oversample of low- and moderate-income households;
2. young adults ages 19–29; and
3. older adults ages 50–70.

The Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011, was conducted online between June 24 and July 5, 2011, by Knowledge Networks, among a representative sample of adults ages 19 to 64. The survey sample was drawn from KnowledgePanel—a probability-based online panel that is representative of the U.S. population and includes cell-phone only and low-income households that are typically difficult to reach using traditional telephone surveys and random digit dialing (RDD) sampling.[i]

To develop KnowledgePanel, address-based sampling is used to randomly select households in the United States to be recruited into the panel (prior to 2009, Knowledge Networks recruited via RDD telephone sampling). Households who do not have Internet are provided with access to the Internet and laptops, if needed. KnowledgePanel consists of about 50,000 U.S. residents age 18 and older. From this panel, 3,603 adults ages 19 to 64 were randomly sampled and invited by e-mail to complete an online questionnaire in either English or Spanish. The survey was completed by 2,134 respondents, yielding a 59 percent completion rate among sampled respondents.[ii] The sample was stratified by income to allow more detailed analysis of responses from low-income respondents. The final sample includes 977 low-income adults who have incomes below 250 percent of the federal poverty level ($55,875 for a family of four).

Statistical results are weighted to correct for the stratified sample design and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population ages 19 to 64 by gender, age, race/ethnicity, education, poverty level, census region, metropolitan area, Internet access, and primary language using the U.S. Census Current Population Survey March 2011, the CPS supplemental survey measuring Internet access (from October 2010), and the Pew Hispanic Center Survey (2010) for Spanish language proficiency distributions. The resulting weighted sample is representative of the approximately 186.7 million U.S. adults ages 19 to 64. In the analysis, respondents' insurance status in the past 12 months is classified as either insured all year, insured when surveyed but with a gap in insurance during the past 12 months, or currently uninsured. The study also classified adults by income as a percent of the federal poverty level. The survey has an overall margin of sampling error of +/– 3 percentage points at the 95 percent confidence level.

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[i] According to the Centers for Disease Control and Prevention (January–June 2010), approximately 28.6 percent of all U.S. households cannot be contacted through RDD sampling alone.

[ii] The American Association of Public Opinion Research response rate is 6.1 percent, calculated by multiplying the share of the households nationwide who were invited to take part in the KnowledgePanel and who agreed to participate (household recruitment rate, 16.8%), times the share of the households who agreed to participate in the panel and who went on to complete the initial profile questionnaire (household profile rate, 62.3%), times the share of the representative sample of 3,603 members randomly drawn from the KnowledgePanel for this study who ultimately completed the online questionnaire (study completion rate, 58.6%).

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Acknowledgments

The authors thank Karen Davis, Melinda Abrams, Barry Scholl, and Tony Shih for helpful comments, and Deborah Lorber, Chris Hollander, Paul Frame, and Suzanne Augustyn for editorial support and design.


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